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TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 62  
6010.58-M  
MARCH 16, 2012**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE REIMBURSEMENT MANUAL (TRM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE: COMBINED CODING AND CLARIFICATION UPDATES - 2011**

**CONREQ: 15443**

**PAGE CHANGE(S): See page 2.**

**SUMMARY OF CHANGE(S): See page 3.**

**EFFECTIVE AND IMPLEMENTATION DATE: As indicated, otherwise upon direction of the Contracting Officer.**

**This change is made in conjunction with Feb 2008 TPM, Change No. 61.**

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**ATTACHMENT(S): 38 PAGE(S)  
DISTRIBUTION: 6010.58-M**

**CHANGE 62**  
**6010.58-M**  
**MARCH 16, 2012**

**REMOVE PAGE(S)**

**CHAPTER 1**

Section 20, pages 3 and 4

**CHAPTER 4**

Section 3, pages 3 and 4

Section 4, pages 3 - 7

**CHAPTER 12**

Section 5, pages 1 - 8

**CHAPTER 13**

Section 2, pages 17 - 20

**APPENDIX A**

pages 15 - 31

**INSERT PAGE(S)**

Section 20, pages 3 and 4

Section 3, pages 3 and 4

Section 4, pages 3 - 7

Section 5, pages 1 - 8

Section 2, pages 17 - 20

pages 15 - 31

## **SUMMARY OF CHANGES**

### **CHAPTER 1**

1. Section 20. Clarifies the language to bring the policy into compliance with the State Agency Billing Agreement (see Chapter 1, Addendum A).

### **CHAPTER 4**

2. Section 3. Corrected a typographical error to read \$52.00.
3. Section 4. Eliminated the requirement for TRICARE beneficiaries, who were awarded Social Security Disability Insurance (SSDI) on appeal, to enroll in Medicare Part B back to their Medicare Part A effective date. Effective as of October 28, 2009.

### **CHAPTER 12**

4. Section 5. Providers clarification to allow referral to HHC by an attending physician rather than solely a PCM.

### **CHAPTER 13**

5. Section 2. APCs 0172 and 0173 are updated to 0175 and 0176 to match Medicare's update as of January 1, 2011.

### **APPENDIX A**

6. Added new Acronyms.



# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Chapter 1, Section 20

### State Agency Billing

CONDITION	PROCEDURE
Diagnosis Missing	Waive on office visits (unless services appear to be for a routine physical or related to other excluded services); consultations; drugs; lab; x-ray; assistant surgeon and anesthesiology. Use International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code 799.9 in absence of a correct code.
Diagnosis Missing	Require on hospital, surgery, and mental health. For DME, if the record provides information other than a diagnosis which can reasonably support the payment, proceed. Return the incomplete claim, which requires a diagnosis, to the state for supporting information.
Timely filing limits.	The state shall file no later than (NLT) one year following the date of service: one year after the date the prescription was filled; one year after the date of discharge if the services were rendered during an inpatient admission; or one year after the state received the results of the annual data match from the Defense Manpower Data Center (DMDC), Defense Enrollment Eligibility Reporting System (DEERS) Division. For waivers, see the TOM, <a href="#">Chapter 8, Section 3, paragraph 2.0</a> .

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#### 2.1.3 TRICARE Encounter Data (TED) Reporting of State Agency Claims

Claims received for state agencies will be processed with the Special Processing Code '1' on TEDs (see the TSM, [Chapter 2](#)). TED coding will follow the basic requirements for a participating claim with the state Medicaid agency designated as the payee. The amount paid by the government must be reported in the Amount Paid by Government Contractor field.

#### 2.1.4 Development with State Agencies

States are obligated to provide the data needed to process the claims they submit, including eligibility and other beneficiary information. In some cases, the contractor will need to develop data through DEERS or other in-house information to accurately process the claim. For other required data, or in case of failure to locate essential information, the contractor **shall deny** the claim. If a state routinely fails to submit required data on its claims, the contractor shall contact the state agency and request cooperation. **TRICARE Management Activity (TMA)** shall be advised of any such problems and the results of any contacts.

#### 2.1.5 Duplicate Checking

Contractors shall ensure that precautions are taken to prevent duplicate payments, as provided in the TOM, [Chapter 8, Section 9](#). In cases where the exact type of service data has not been provided, but a duplication of types of service is apparent; e.g., apparent duplication of lab and office services, the contractor shall attempt to resolve the case with the data available in-house. If the matter cannot be resolved, assume duplication and deny the claim. If the state agency has information to the contrary, it may resubmit with the necessary documentation to refute the assumption. If a beneficiary or provider has submitted claims for services directly to TRICARE and the same services have also been sent to the state for Medicaid payment, the possibility of fraud must be considered. Since the patient would have been TRICARE-eligible, any fraud would have been an offense against the state program. Return the claim to the state agency and advise them of the facts including that payment has been made by TRICARE. The contractor shall cooperate in any state investigation to the extent possible under TRICARE guidelines. In any case of doubt about what information can be released in an investigation, contact TMA for instructions.

### 2.1.6 Non-Availability Statement (NAS)

The state must include the address of the beneficiary on the claim and the contractor shall verify whether a NAS is required, using normal processing rules, including a check of the related history files to determine if an NAS is on file. If an NAS is required, and none is available, the claim will be denied and the State Medicaid Agency notified on the Explanation of Benefits (EOB). No further action is required by the contractor.

### 2.1.7 Providers

Providers must be TRICARE-approved or TRICARE-eligible in accordance with the TOM, [Chapter 2](#). If the provider named on the claim is not on the contractor provider files, but is in a category which is normally acceptable under TRICARE; e.g., a physician, psychologist, hospital, etc., the contractor shall follow normal procedures to certify. If the provider is not in a certifiable category under the contract, return the claim to the state.

### 2.1.8 Third Party Liability (TPL)

When submitting claims to TRICARE for recovery of payments made, the state agency should attach information regarding possible TPL for those claims which carry a diagnosis requiring development (see the TOM, [Chapter 10](#)). However, if the TPL data submitted is not adequate to provide all the information required, return the claim to the state agency to obtain the necessary information. **If the state agency does not provide the necessary information within 35 days, the claim shall be denied.** It is expected that the state agency will have a fully developed file to establish or to rule out possible TPL. If TPL is involved, the state should have exercised its subrogation rights and the state's beneficiary claim file should reflect complete data, including the amount paid under TPL. Where TPL does exist, the TRICARE claim liability should be minimal. The contractor should **not** contact the beneficiary or the provider(s).

## 2.2 Reimbursement Procedures and Requirements

The contractor shall reimburse the State Medicaid Agency directly for all claims submitted by the agency providing an EOB for each claim, unless arrangements and agreement between the contractor and the state agency provide for a summary payment voucher. **No EOB or other notice will be sent to either the beneficiary or the provider.** The allowance determination shall be based on the amount billed to the Medicaid Agency by the provider of care. The contractor shall calculate the net amount which would have been payable by TRICARE including, when appropriate, the COB reduction, deductible and cost-share amounts in the determination. The state shall be paid the lesser of the amount it actually paid or the amount that TRICARE would have paid. The Medicaid billing by a provider is frequently less than the provider's customary charge. These charges shall not be included in the determination of the prevailing charges for an area. If a provider of care subsequently bills, requesting payment for the difference between the Medicaid payment and the amount customarily billed, the claim shall be denied as a duplicate. No additional payment shall be made. If a service which would be allowable by TRICARE has been denied by Medicaid and is subsequently submitted by a provider of care, the charge shall be considered as any other claim.

- END -

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 4, Section 3

Coordination Of Benefits (COB)

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**Step 3:** From the hospital's charges or the OHI allowed amount if lower and if the beneficiary's liability is limited under the OHI (or when lower, the amount the hospital is obligated to accept as payment in full) subtract the actual amount paid by the OHI.

**Step 4:** From the provider's charges or the OHI allowed amount if lower and if the beneficiary's liability is limited under the OHI (or when lower, the amount the hospital is obligated to accept as payment in full) subtract any applicable beneficiary cost-sharing amounts.

**Step 5:** Compare the amounts in Steps 1 through 4 and pay the lowest.

**5.0 THE TRICARE DEDUCTIBLE IN DOUBLE COVERAGE**

In the initial claim(s) each fiscal year, the calculation in Step 1 must include appropriate deductions for the TRICARE deductible. This satisfies the TRICARE deductible requirement even in those cases in which the combined payments by TRICARE and the double coverage plan result in payment of the full billed charge.

**Example 1:** Deductible Amount For Family Member Of Active Duty E-4 Or Below.

**Step 1:**

\$ 100.00	- Allowable charge
- 50.00	- TRICARE deductible
<hr/>	
50.00	
x 80%	- TRICARE portion
<hr/>	
\$ 40.00	- Amount payable by TRICARE in the absence of double coverage.

**Step 2:**

\$ 100.00	- Billed charge
- 100.00	- Paid by OHI
<hr/>	
\$ 0.00	- Unpaid balance

**Step 3:** TRICARE makes no payment on this claim, since the double coverage plan paid the bill in full. The beneficiary's individual TRICARE deductible for the fiscal year has been satisfied. Beneficiaries should be encouraged to submit claims to TRICARE even when the double coverage plan has paid the bill in full, since a credit to the TRICARE deductible or the catastrophic cap is possible.

Amounts paid by the OHI are to be credited to the deductible, even if the claim does not require a deductible (e.g., a pharmacy claim when a Standard beneficiary goes to a network pharmacy).

**Example 2:**

**Step 1:**

\$ 240.00	- Allowable charge for a prescription from a network pharmacy
- 3.00	- TRICARE cost-share and deductible (no deductible is charged because the beneficiary went to a network pharmacy)
<hr/>	
\$ 237.00	- TRICARE payment in absence of double coverage

**Step 2:**

\$ 240.00	- Billed charge
- 180.00	- Amount paid by double coverage
<hr/>	
\$ 60.00	- Unpaid balance

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 4, Section 3

Coordination Of Benefits (COB)

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**Step 3:** TRICARE pays the \$60 balance, since it is the lower of Steps 1 and 2. The beneficiary's bill has been paid in full, and the beneficiary's individual deductible for the fiscal year has been satisfied.

Charges applied to the double coverage plan's deductible may also be applied to the TRICARE deductible if the charge was incurred in the appropriate fiscal year and if the TRICARE deductible is unmet at the time the charge is submitted.

**Example 3:**

**Step 1:**

\$ 50.00	- Allowable charge
- 50.00	- TRICARE deductible
<hr/>	
\$ 0.00	- TRICARE payment in absence of double coverage

**Step 2:**

\$ 50.00	- Billed charge
- 0.00	- Amount paid by OHI - total billed charge credited to double coverage plan's deductible.
<hr/>	
\$ 50.00	- Unpaid balance

**Step 3:** The beneficiary is responsible for paying the \$50.00 unpaid balance. The full billed charge was credited to the deductible by both TRICARE and the double coverage plan. TRICARE pays nothing on this claim, since the TRICARE payment in the absence of double coverage is zero. However, the beneficiary's TRICARE deductible for the fiscal year is satisfied.

If information concerning the double coverage plan's deductible is not submitted with the claim, contractors are not required to develop for it. Neither are they required to adjust a previously processed claim if the TRICARE deductible was satisfied from a claim other than the one from which the double coverage plan's deductible was satisfied.

**Example 4:** Date of Service, July 2002 (Deductible amount for family member of active duty E-4 or below.)

**Step 1:**

\$ 60.00	- Allowable charge
- 50.00	- TRICARE deductible
<hr/>	
\$ 10.00	
x 80%	- TRICARE portion
<hr/>	
\$ 8.00	- Amount payable by TRICARE in the absence of double coverage

**Step 2:**

\$ 60.00	- Billed charge
- 0.00	- Paid by double coverage - total billed amount credited deductible
<hr/>	
\$ 60.00	- Unpaid balance

**Step 3:** TRICARE pays \$8.00 on this claim since it is the lower of Steps 1 and 2. The beneficiary is responsible for paying the \$52.00 remainder of the bill. The beneficiary's TRICARE individual deductible for the fiscal year is satisfied.

Above beneficiary has additional care with date of service, April 2002, and this claim is received after the claim for the July services.

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 4, Section 4

#### Specific Double Coverage Actions

20% of the allowable charge). In cases where the beneficiary's access to medical care is limited (i.e., under served areas), the TRICARE contractor may waive the second payer status for the services of a Medicare opt-out provider and pay the claim as the primary payer. In most cases, under served areas will be identified by zip codes for Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs) on the Centers for Medicare and Medicaid Services (CMS) web site at <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/> and will automatically be paid as primary payer. In cases where the zip code for an underserved area is not identified on the CMS web site, or in areas where there are no or limited Medicare participating providers, a written waiver request with justification identifying the county where the service was received and a copy of the provider's private contract will be required by the contractor to pay the claim as the primary payer. TRICARE contractors will identify HPSA or PSA zip codes or the county for underserved areas on the above CMS web site and identify opt out providers based on the Medicare Part B carriers web sites.

**Note:** Under the TRICARE Provider Reimbursement Demonstration Project for the state of Alaska, TRICARE will pay as primary payer for the services of Medicare opt-out providers.

**1.3.1.6** If the service or supply normally is a benefit under both Medicare and TRICARE but Medicare denies payment based on their Competitive Bidding Program (CBP) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), the TRICARE contractor shall process the claim as second payer for otherwise covered items of DMEPOS. In such cases, the TRICARE payment shall be the amount TRICARE would have paid had Medicare processed and paid the claim. Public use files containing the competitive bid single payment amounts per Healthcare Common Procedure Coding System (HCPCS) code are posted on the CMS' competitive bidding contractor's web site: <http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home>. TRICARE contractors shall identify the competitive bid single payment amount using the above CMS web site to identify what Medicare would have allowed had the beneficiary followed Medicare's rules. Implementation of Medicare's DMEPOS CBP pricing is effective January 1, 2011.

**1.3.1.7** Effective October 28, 2009, TRICARE beneficiaries under the age of 65 who became Medicare eligible due to a retroactive disability determination awarded upon appeal remain eligible and are considered to have coverage under the TRICARE program (see the TOM, Chapter 20, Section 1, paragraph 2.6) for the retroactive months of their entitlement to Medicare Part A, notwithstanding the gap in coverage between Medicare Part A and Part B effective dates. For previously processed claims and claims for dates of service before the beneficiary's original Medicare Part B effective date (which corresponds with the date of issuance of the retroactive determination by the Social Security Administration), jurisdiction remains with the contractor that processed the claim. Recoupment actions shall not be initiated and existing actions should be terminated. Out-of-jurisdiction rules apply to claims for dates of service on or after the original Medicare Part B effective date. These claims should be forwarded to the TDEFIC contractor for action. Medicare becomes primary payer effective as of the original Medicare Part B effective date. Eligible beneficiaries are required to keep Medicare Part B in order to maintain their TRICARE coverage for future months, but are considered to have coverage under the TRICARE program for the retroactive months of their entitlement to Medicare Part A.

#### **1.3.2 Services That Are A Benefit Under Medicare But Not Under TRICARE**

TRICARE will make no payment for services and supplies that are not a benefit under TRICARE, regardless of any action Medicare may take on the claim.

### **1.3.3 Services That Are A Benefit Under TRICARE But Not Under Medicare**

If the service or supply is a benefit under TRICARE but not under Medicare, TRICARE will process the claim as the primary payer assessing any applicable deductibles and cost-shares. If the contractor has the documentation (e.g., Medicare transmittal or regulation) that a service or supply on the claim is not a benefit under Medicare, the contractor can process the claim without evidence of processing by Medicare for that service or supply. These claims shall be handled in accordance with [32 CFR 199.10\(a\)\(1\)\(ii\)](#).

### **1.3.4 Services That Are Provided In A Non-Department Of Defense (DoD) Government Facility**

If services or supplies are provided in a TRICARE authorized non-DoD government facility, such as a Department of Veterans Affairs (DVA) hospital pursuant to the TRICARE Policy Manual (TPM), [Chapter 11, Section 2.1](#), Medicare will make no payment. In such cases TRICARE will make payment as the primary payer assessing all applicable deductibles and cost-shares.

**Note:** In order to achieve status as a TRICARE authorized provider, DVA facilities must comply with the provisions of the TPM, [Chapter 11, Section 2.1](#).

### **1.3.5 Services Provided By A Medicare At-Risk Plan**

If the beneficiary is a member of a Medicare at-risk plan (for example, Medicare Plus Choice), TRICARE will pay 100% of the beneficiaries copay for covered services. A claim containing the required information must be submitted to obtain reimbursement.

### **1.3.6 Beneficiary Cost-Shares**

Beneficiary costs shares shall be based on the network status of the provider. Where TRICARE is primary payer, cost-shares for services received from network providers shall be TRICARE Extra cost-shares. Services received from non-network providers shall be TRICARE Standard cost-shares. Network discounts shall only be applied when the discount arrangement specifically contemplated the TFL population.

### **1.3.7 Application Of Catastrophic Cap**

Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

**1.4** End Stage Renal Disease (ESRD) in TRICARE beneficiaries less than 65 years of age - Medicare is the primary payer and TRICARE is the secondary payer for beneficiaries entitled to Medicare Part A and who have Medicare Part B coverage.

## **2.0 TRICARE AND MEDICAID**

Medicaid is essentially a welfare program, providing medical benefits for persons under various state welfare programs (such as Aid to Dependent Children) or who qualify by reason of being determined to be "medically indigent" based on a means test. In enacting Public Law 97-377, it was the intent of Congress that no class of TRICARE beneficiary should have to resort to welfare

programs, and therefore, Medicaid was exempted from these double coverage provisions. Whenever a TRICARE beneficiary is also eligible for Medicaid, TRICARE is always the primary payer. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined to be a TRICARE beneficiary, TRICARE shall reimburse the appropriate Medicaid agency for the amount TRICARE would have paid in the absence of Medicaid benefits or the amount paid by Medicaid, whichever is less. See [Chapter 1, Section 20](#).

### **3.0 MATERNAL AND CHILD HEALTH PROGRAM/INDIAN HEALTH SERVICE (IHS)**

Eligibility for health benefits under either of these two Federal programs is not considered to be double coverage (see [Section 1](#)).

### **4.0 TRICARE AND THE DVA**

Eligibility for health care through the DVA for a service-connected disability is not considered double coverage. If an individual is eligible for health care through the DVA and is also eligible for TRICARE, he/she may use either TRICARE or veterans benefits. In addition, at any time a beneficiary may get medically necessary care through TRICARE, even if the beneficiary has received some treatment for the same episode of care through the DVA. However, TRICARE will not duplicate payments made by or authorized to be made by the DVA for treatment of a service-connected disability.

### **5.0 TRICARE AND WORKER'S COMPENSATION**

TRICARE benefits are not payable for work-related illness or injury which is covered under a Worker's Compensation program. The TRICARE beneficiary may not waive his or her Worker's Compensation benefits in favor of using TRICARE benefits. If a claim indicates that an illness or injury might be work related, the contractor will process the claim following the provisions as provided in TOM, [Chapter 10, Section 5, paragraphs 5.0 and 6.0](#) and refer the claim to the Uniformed Service Claims Office for recovery, if appropriate.

### **6.0 TRICARE AND SUPPLEMENTAL INSURANCE PLANS**

#### **6.1 Not Considered Double Coverage**

Supplemental plans (see [Chapter 1, Section 26](#)) or complementary insurance coverage is a health insurance policy or other health benefit plan offered by a private entity to a TRICARE beneficiary, that primarily is designed, advertised, marketed, or otherwise held out as providing payment for expenses incurred for services and items that are not reimbursed under TRICARE due to program limitations, or beneficiary liabilities imposed by law. TRICARE recognizes two types of supplemental plans, general indemnity plans and those offered through a direct service Health Maintenance Organization (HMO). Supplemental insurance plans are not considered double coverage. TRICARE benefits will be paid without regard to the beneficiary's entitlement to supplemental coverage.

#### **6.2 Income Maintenance Plans**

Income maintenance plans pay the beneficiary a flat amount per day, week or month while the beneficiary is hospitalized or disabled. They usually do not specify a type of illness, Length-Of-

Stay (LOS), or type of medical service required to qualify for benefits, and benefits are not paid on the basis of incurred expenses. Income maintenance plans are not considered double coverage. TRICARE will pay benefits without regard to the beneficiary's entitlement to an income maintenance plan.

### **6.3 Other Secondary Coverage**

Some insurance plans state that their benefits are payable only after payment by all government, Blue Cross/Blue Shield (BC/BS) and private plans to which the beneficiary is entitled. In some coverages, however, it provides that if the beneficiary has no other coverage, it will pay as a primary carrier. Such plans are double coverage under TRICARE law, regulation, and policy and are subject to the usual double coverage requirements.

### **7.0 SCHOOL COVERAGE - SCHOOL INFIRMARY**

TRICARE benefits shall be paid for covered services provided to students by a school infirmary provided that the school imposes charges for the services on all students or on all students who are covered by health insurance.

### **8.0 TRICARE AND PREFERRED PROVIDER ORGANIZATIONS (PPOs)**

See [Chapter 1, Section 25](#).

### **9.0 DOUBLE COVERAGE AND EXTENDED CARE HEALTH OPTION (ECHO)**

All double coverage rules and procedures which apply to claims under the basic program are also to be applied to ECHO claims. All local resources must be considered and utilized before TRICARE benefits under the ECHO may be extended. If an ECHO beneficiary is eligible for other federal, state, or local assistance to the same extent as any other resident or citizen, TRICARE benefits are payable only for amounts left unpaid by the other program, up to the TRICARE maximums established in TPM, [Chapter 9](#). The beneficiary may not waive available federal, state, or local assistance in favor of using TRICARE.

**Note:** The requirements of [paragraph 9.0](#) notwithstanding, TRICARE is primary payer for medical services and items that are provided under Part C of the Individuals with Disabilities Education Act in accordance with the Individualized Family Service Plan (IFSP) and that are otherwise allowable under the TRICARE Basic Program or the ECHO.

### **10.0 PRIVATELY-PURCHASED, NON-GROUP COVERAGE**

Privately-purchased, non-group health insurance coverage is considered double coverage.

### **11.0 LIABILITY INSURANCE**

If a TRICARE beneficiary is injured as a result of an action or the negligence of a third person, the contractor must develop the claim(s) for potential Third Party Liability (TPL) (see the TOM, [Chapter 10, Section 5](#)). The contractor shall pursue the Government's subrogation rights under the Federal Medical Care Recovery Act (FMCRA), if the other health insurance does not cover all expenses.

## **12.0 TRICARE AND PRE-PAID PRESCRIPTION PLANS**

If the beneficiary has a “pre-paid prescription plan,” where the beneficiary pays only a “flat fee” no matter what the actual cost of the drug, the contractor shall cost-share the fee and not develop for the actual cost of the drug, since the beneficiary is liable only for the “fee.”

## **13.0 TRICARE AND STATE VICTIMS OF CRIME COMPENSATION PROGRAMS**

Effective September 13, 1994, State Victims of Crime Compensation Programs are not considered double coverage. When a TRICARE beneficiary is also eligible for benefits under a State Victims of Crime Compensation Program, TRICARE is always the primary payer over the State Victims of Crime Compensation Programs.

## **14.0 SURROGATE ARRANGEMENTS**

Contractual arrangements between a surrogate mother and adoptive parents are considered other coverage. For pregnancies in which the surrogate mother is a TRICARE beneficiary, services and supplies associated with antepartum care, postpartum care, and complications of pregnancy may be cost-shared only as a secondary payer, and only after the contractually agreed upon amount has been exhausted. This applies where contractual arrangements for payment include a requirement for the adoptive parents to pay all or part of the medical expenses of the surrogate mother as well as where contractual arrangements for payment do not specifically address reimbursement for the mother’s medical care. If brought to the contractor’s attention, the requirements of TOM, [Chapter 10, Section 5, paragraph 2.10](#) would apply.

- END -



## Home Health Benefit Coverage And Reimbursement - Primary Provider Status And Episodes Of Care

Issue Date:

Authority: [32 CFR 199.2](#); [32 CFR 199.4\(e\)\(21\)](#); [32 CFR 199.6\(a\)\(8\)\(i\)\(B\)](#); [32 CFR 199.6\(b\)\(4\)\(xv\)](#); and [32 CFR 199.14\(j\)](#)

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### 1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### 2.0 ISSUE

This policy describes the methods used in designating the primary provider of home health services and for tracking the **Episodes Of Care (EOCs)** for payment under the Home Health Agency Prospective Payment System (HHA PPS).

### 3.0 POLICY

#### 3.1 Background

**3.1.1** With the advent of the HHA PPS and home health Consolidated Billing (CB), Medicare had to establish a means of identifying a "primary" HHA for payment purposes (i.e., a HHA that would receive payment for all services during a designated **EOC**). Medicare addressed this problem through the establishment of an administratively complex on-line inquiry transaction system [i.e., a Health Insurance Query for Health Agencies (HIQH)] whereby other home health providers could determine whether or not the beneficiary was currently in a home health **EOC**. This on-line query system required the establishment of a HHA PPS episode auxiliary file which is continually updated as Requests for Anticipated Payments (RAPs) and claims are processed through the Regional Home Health Intermediary's (RHHI) claims processing systems. The HIQH system must be able to immediately return the following information to providers querying the system: 1) contractor and provider numbers; 2) episode start and end dates; 3) period status indicator; 4) HHA benefit periods; 5) secondary payer information; 6) hospice periods; and 7) HIQH header information. The HIQH transaction system must also be able to access 36 episode iterations displayed two at a time.

**3.1.2** The implementation and maintenance of such an on-line transactional query system would be administratively burdensome and costly for the program. It would have to be maintained by one of the claims processing subcontractors since it is a national system requiring continual on-line updating. Determining "primary" provider status from the query system (i.e., the first RAP or,

under special circumstances, the first claim submitted and processed by the RHHI) would circumvent the contractors' utilization management responsibilities/requirements under their existing Managed Care Support (MCS) contracts. In other words, the contractors would no longer be able to assess and direct Home Health Care (HHC) within their region(s). Designation of primary HHA status (i.e., the only HHA allowed to receive payment for services rendered during an EOC) would be dependent on the first RAP or claim submitted and processed for a particular EOC. The determination of where and by whom the services are provided would be dependent on the provider instead of the Managed Care Support Contractor (MCSC).

**3.1.3** An alternative approach is being adopted that will meet the primary goals of ensuring Medicare PPS payment rates and benefit coverage while retaining utilization management. Under this alternative approach, the preauthorization process will determine "primary status" of the HHA. Authorization screens (part of the automated authorization file) will be used to house pertinent episode data. This alternative will necessitate contractor preauthorization for all HHC (i.e., HHC delivered under both Prime and Standard). Expansion of the existing authorization requirements is a viable option given the fact that one of the MCSCs is already authorizing HHC for standard beneficiaries under its contract. The alternative authorization process is preferable to the development and maintenance of a national on-line transactional query system, given its enormous implementing and maintenance costs. Adoption of the above alternative will preclude implementation of Medicare's on-line transactional system and maintenance of complex auxiliary episode files. However, adoption of this alternative process does not preclude the prescribed conventions currently in place for establishing EOCs; e.g., transfers, discharges and readmissions to the same facility within 60-day episodes, Significant Changes In Condition (SCICs), Low Utilization Payment Adjustments (LUPAs), and continuous EOCs will all be monitored and authorized as part of the authorization process. Contractors will maintain and update episode data on expanded authorization screens.

## **3.2 Designation of Primary Provider**

### **3.2.1 Preauthorization Process**

The preauthorization process is critical to establishment of primary provider status under the HHA PPS; i.e., designating that HHA which may receive payment under the CB provisions for home health services provided under a Plan of Care (POC).

**3.2.1.1** The contractor is responsible for coordinating referral functions for all Military Health System (MHS) beneficiaries (both Prime and Standard) seeking HHC. In other words, HHC can only be accessed by TRICARE beneficiaries upon referral by the PCM, or attending physician, and with preauthorization by the contractor. The contractor shall establish and maintain these functions to facilitate referrals of beneficiaries to HHAs. For example, a beneficiary in need of home health services will request preauthorization and placement by the MCSC or other contractor designee. The MCSC will search its network for a HHA which will meet the needs of the requesting beneficiary. The beneficiary will be granted preauthorization approval for home health services provided by the selected HHA. The selected HHA will in turn be notified of its primary provider status under TRICARE (i.e., the selected HHA will be notified that it will be the only HHA authorized for payment for services provided to the referred TRICARE beneficiary) and must submit a request for anticipated payment after the first service has been rendered. The RAP will initiate the EOC under the preauthorization process.

**3.2.1.2** The preauthorization process will extend to all intervening events occurring during the episode period (e.g., preauthorization will be required for transfers to another HHA and readmission to the same HHA within 60 days of previous discharge). In each case, the MCSC will maintain responsibility for designating primary provider status under the HHA PPS.

### **3.2.2 Data Requirement/Maintenance**

The tax identification number (9-18 positions) of the designated primary provider (HHA) will be maintained and updated on the automated authorization file (i.e., the authorization screen).

### **3.3 Opening and Length of HHA PPS Episode.**

While the authorization process will take the place of the HIQH in designation of primary provider status and maintenance and updating of pertinent episode data, it will not preclude the following conventions for reporting and payment of HHA EOCs:

**3.3.1** In most cases, an HHA PPS episode will be opened by the receipt of a RAP, even if the RAP or claim has zero reimbursement. The MCSC will have already notified the selected HHA of its primary status for billing under the consolidated standards prior to submission of the RAP. The preauthorization requirement will negate the need for a query system (i.e., the need for keeping other home health providers informed of whether a beneficiary is already under the care of another HHA), since providers will be keenly aware of this requirement for primary status under TRICARE. In other words, if an HHA has not received prior notification from the MCSC of its selection for treatment of a TRICARE beneficiary, it does not have primary provider status under the Program.

**3.3.2** Claims, as opposed to RAPs, will only open episodes in one special circumstance: when a provider knows from the outset that four or fewer visits will be provided for the entire episode, which always results in a LUPA, and therefore decides to forego the RAP so as to avoid recoupment of the difference of the large initial percentage episode payment and the visit-based payment. This particular billing situation exception is referred to as a No-RAP LUPA.

**3.3.3** Multiple episodes can be opened for the same beneficiary at the same time. The same HHA may require multiple episodes to be opened for the same beneficiary because of an unexpected readmission after discharge, or if for some reason a subsequent episode RAP is received prior to the claim for the previous episode. Multiple episodes may also occur between different providers if a transfer situation exists. Again, however, the MCSCs will always be aware of the intervening events (e.g., transfers to another HHAs or discharge and readmission to the same facility during the same 60-day EOC) due to ongoing utilization review and preauthorization requirements under contractors' managed care systems. The MCSC will be responsible for designating primary provider status whether it be for a new provider, in the case of transfer, or readmission to the same provider during a 60-day EOC. The contractors' system will post RAPs received with appropriate transfer and re-admit indicators to facilitate the creation of multiple episodes. Same-day transfers are permitted, such that an episode for one agency, based on the claim submitted by the agency, can end the same date as an episode was opened by another agency for the same beneficiary, assuming preauthorization has been initiated and granted by the MCSC.

**3.3.4** When episodes are created from RAPs, the system calculates a period end date that does not exceed the start plus 59 days. The system will assure no episode exceeds this length under any

circumstance, and will auto-adjust the period end date to shorten the episode if needed based on activity at the end of the episode (i.e., shortened by transfer).

**3.3.5** The system will reject RAPs and claims with statement dates overlapping existing episodes, including No-RAP LUPA claims, unless a transfer or discharge and re-admit situation is indicated. The system will also reject claims in which the dates of the visits reported for the episode do not fall within the episode period established by the same agency. Sixty day episodes, starting on the original period start date, will remain on record in these cases.

**3.3.6** The system will auto-cancel claims, and adjust episode lengths, when episodes are shortened due to receipt of other RAPs or claims indicating transfer or readmission. The auto-adjusted episode will default to end the day before the first date of service of the new RAP or claim causing the adjustment, even though the episode length may change once claims finalizing episodes are received. Payment for the episode is automatically adjusted [a Partial Episode Payment (PEP) adjustment] without necessitating re-billing by the HHA. If, when performing such adjustments, there is no claim in paid status for the previous episode that will receive the PEP adjustment, the system will adjust the period end date; however, if the previous claim is in paid status, both the claim and the episode will be adjusted.

**3.3.7** In a PEP situation, if the first episode claim contains visits with dates in the subsequent episode period, the claim of the first episode will be rejected by the system with a reject code that indicates the date of the first overlapping visit. The claim rejected by the system will then be returned to the HHA by the contractor for correction. If the situation is also a transfer, when the first HHA with the adjusted episode subsequently receives a rejected claim, the agency can either re-bill by correcting the dates, or seek payment under arrangement from the subsequent HHA. For readmission and discharge, the agency may correct the erroneously billed dates for its own previously-submitted episode, but corrections and adjustments in payment will be made automatically as appropriate whether the HHA submits corrections or not.

**3.3.8** If the from dates on two simultaneously received RAPs, or No-RAP LUPA claims, overlap, the system will reject the one for which there is no prior authorization (i.e., the RAP from the HHA for which there was no designated primary provider status by the MCSC). In such cases, contractors will return the claims rejected by the system to providers.

**3.3.9** If a claim is canceled by an HHA, the system will cancel the episode. If an HHA cancels a RAP, the system will also cancel the episode. When RAPs or claims are auto-canceled or canceled by the system, the system will not cancel the episode. A contractor may also take an action that results in cancellation of an episode, usually in cases of fraudulent billing. Other than cancellation, episodes are closed by final processing of the claim for that episode.

#### **3.4 Other Editing and Changes for HHA PPS Episodes**

**3.4.1** The system will assure that the final from date on the episode claim equals the calculated period end date for the episode if the patient status code for the claim indicates the beneficiary will remain in the care of the same HHA (patient status code 30).

**3.4.2** If the patient dies, represented by a patient status code of 20, the episode will not receive a PEP adjustment (i.e., the full payment episode amount will be allotted), but the through date on the claim will indicate the date of death instead of the episode end date.

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 12, Section 5

#### Home Health Benefit Coverage And Reimbursement - Primary Provider Status And Episodes Of Care

---

**3.4.3** When the patient status of a claim is 06, indicating transfer, the episode period end date will be adjusted to reflect the through date of that claim, and payment is also adjusted.

**3.4.4** The system will permit a "transfer from" and a "transfer to" agency to bill for the same day when it is the date of transfer and a separate RAP/claim is received overlapping that 60-day period containing either a transfer or a discharge-readmit indicator.

**3.4.5** When the status of the claim is 01, no change is made in the episode length or claim payment unless a separate RAP/Claim is received overlapping that 60-day period and containing either a transfer or a discharge-readmit indicator.

**3.4.6** The system will also act on source of admission codes on RAPs; for example, "B" (indicating transfer) and "C" (indicating readmission after discharge by the same agency in the same 60-day period) will open new episodes. In addition to these two codes, though, any approved source of admission code may appear, and these other codes alone will not trigger creation of a new episode.

**3.4.7** Claims for institutional inpatient services [i.e., inpatient hospital and skilled nursing facility (SNF) services] will continue to have priority over claims for home health services under HHA PPS. Beneficiaries cannot be institutionalized and receive homebound care simultaneously. Therefore, if an HHA PPS claim is received, and the system finds dates of service on the HH claims that fall within the dates of an inpatient or SNF claim (not including the dates of admission and discharge), the system will reject the HH claim.

**3.4.8** A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues, although a SCIC adjustment is likely to apply. Occurrence span code 74, previously used in such situations, should not be employed on HHA PPS claims.

**3.4.9** If an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, there would be one shortened HHA PPS episode completed before the inpatient stay ending with the discharge, and another starting after the inpatient stay, with delivery of home care never overlapping the inpatient stay. The first shortened episode would receive a PEP adjustment only because the beneficiary was receiving more home care in the same 60-day period. This would likely reduce the agency's payment overall. The agency should cancel the PEP claim and the readmission RAP in these cases and re-bill a continuous EOC.

**3.4.10** The system will edit to prevent duplicate billing of Durable Medical Equipment (DME). Consequently, the system must edit to ensure that all DME items billed by HHAs have a line-item date of service and Healthcare Common Procedure Coding System (HCPCS) coding, though home health CB does not apply to DME by law.

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 12, Section 5

Home Health Benefit Coverage And Reimbursement - Primary Provider Status And Episodes Of Care

**3.5 Chart Summarizing the Effects of RAP/Claim Actions on the HHA PPS Episode**

TRANSACTION	HOW SYSTEM IS IMPACTED	HOW OTHER PROVIDERS ARE IMPACTED
Initial RAP (Percentage Payments 0-60)	Open an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day.	<ul style="list-style-type: none"> <li>• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present.</li> <li>• No-RAP LUPA claims will be rejected unless a transfer source code is present.</li> </ul>
Subsequent Episode RAP	Opens another subsequent episode using RAP's "from" date; "through" date is automatically calculated to extend through next episode.	<ul style="list-style-type: none"> <li>• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present.</li> <li>• No-RAP LUPA claims will be rejected unless a transfer source code is present.</li> </ul>
Initial RAP with Transfer Source Code of B	Opens an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day.	<ul style="list-style-type: none"> <li>• The period end date on the RAP of the HHA the beneficiary is transferring from is automatically changed to reflect the day before the from date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from cannot bill for services past the date of the transfer.</li> <li>• Another HHA cannot bill during this episode unless another transfer situation occurs.</li> </ul>
RAP Cancellation by Provider or Contractor	The episode record is deleted from system.	<ul style="list-style-type: none"> <li>• No episode exists to prevent RAP submission or No-RAP LUPA claim submission.</li> </ul>
RAP Cancellation by System	The episode record remains open on system	<ul style="list-style-type: none"> <li>• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present.</li> <li>• No-RAP LUPA claims will be rejected unless a transfer source code is present.</li> <li>• To correct information on this RAP, the original RAP must be replaced, canceled by the HHA and then re-submitted once more with the correct information.</li> </ul>
Claim (full)	60-day episode record completed; episode "through" date remains at the 60th day; Date of Latest Billing Action (DOLBA) updates with date of last service.	<ul style="list-style-type: none"> <li>• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present.</li> <li>• No-RAP LUPA claims will be rejected unless a transfer source code is present.</li> </ul>
Claim (discharge with goals met prior to Day 60)	Episode record complete; episode "through" date remains at the 60th day; DOLBA updates with date of last service.	<ul style="list-style-type: none"> <li>• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present.</li> <li>• No-RAP LUPA claims will be rejected unless a transfer source code is present.</li> </ul>
Claim (transfer)	Episode completed; episode period end date reflects transfer; DOLBA updates with date of last service	<ul style="list-style-type: none"> <li>• A RAP or No-RAP LUPA claim will be accepted if the "from" date is on or after episode "through" date.</li> </ul>

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 12, Section 5

Home Health Benefit Coverage And Reimbursement - Primary Provider Status And Episodes Of Care

TRANSACTION	HOW SYSTEM IS IMPACTED	HOW OTHER PROVIDERS ARE IMPACTED
No-RAP LUPA Claim	Opens an episode record using claim's "from" date; the "through" date automatically calculated to extend through 60th day; DOLBA updates with date of last service.	<ul style="list-style-type: none"> <li>• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present.</li> <li>• Other No-RAP LUPA claims will be rejected unless a transfer source is present.</li> <li>• Because a RAP is not submitted in this situation until the No-RAP LUPA claim is submitted, another provider can open an episode by submitting a RAP or by submitting a No-RAP LUPA Claim.</li> </ul>
Claim (adjustment)	No impact on the episode unless adjustment changes patient status to transfer.	<ul style="list-style-type: none"> <li>• No impact</li> </ul>
Claim Cancellation by Provider or Contractor	The episode is deleted from system.	<ul style="list-style-type: none"> <li>• No episode exists to prevent RAP submission or No-RAP LUPA claim submission.</li> </ul>
Claim Cancellation by System	The episode record remains open on system.	<ul style="list-style-type: none"> <li>• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present.</li> <li>• No-RAP LUPA claims will be rejected unless a transfer source code is present.</li> </ul>

**3.6 Episode Data Requirement**

The contractor's authorization screen (part of its automated authorization file) will show whether or not the beneficiary is currently in a home health EOC (being served by a primary HHA), along with the following information:

**3.6.1** The beneficiary's name and sex.

**3.6.2** Pertinent contractor and provider number.

**3.6.3** Period Start and End Dates. The start date is received on a RAP or claim, and the end date is initially calculated to be the 60th day after the start date, changed as necessary when the claim for the episode is finalized.

**3.6.4** Date of Earliest Billing Action (DOEBA) and DOLBA. Dates of earliest and latest billing activity.

**3.6.5** Period Status Indicator. The patient status code on HHA PPS claim, indicating the status of the HH patient at the end of the period.

**3.6.6** Transfer/Readmit Indicator. Source of admission codes taken from the RAP or claim as an indicator of the type of admission (transfer, readmission after discharge).

**3.6.7** The Health Insurance PPS (HIPPS) Code(s). Up to six for any episode, representing the basis of payment for episodes other than those receiving a LUPA.

**3.6.8** Principle Diagnosis Code and First Other Diagnosis Code. From the RAP or overlaying claim.

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 12, Section 5

Home Health Benefit Coverage And Reimbursement - Primary Provider Status And Episodes Of Care

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**3.6.9** A LUPA Indicator. Received from the system indicating whether or not there was a LUPA episode; and

**3.6.10** At least six of the most recent episodes for any beneficiary.

- END -

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 13, Section 2

#### Billing And Coding Of Services Under Ambulatory Payment Classifications (APC) Groups

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**3.7.4** PHP should be a highly structured and clinically-intensive program, usually lasting most of the day. Since a day of care is the unit that defines the structure and scheduling of partial hospitalization services, a two-tiered payment approach has been retained, one for days with three services (APC 0175) and one for days with four or more services (APC 0176) to provide PHPs scheduling flexibility and to reflect the lower costs of a less intensive day.

**3.7.4.1** However, it was never the intention of this two-tiered per diem system that only three units of service should represent the number of services provided in a typical day. The intention of the two-tiered system was to cover days that consisted of three units of service only in certain limited circumstances; e.g., three-service days may be appropriated when a patient is transitioning towards discharge or days when a patient who is transitioning at the beginning of his or her PHP stay.

**3.7.4.2** Programs that provide four or more units of service should be paid an amount that recognizes that they have provided a more intensive day of care. A higher rate for more intensive days is consistent with the goal that hospitals provide a highly structured and clinically-intensive program.

**3.7.4.3** The OCE logic will require that hospital-based PHPs provide a minimum of three units of service per day in order to receive PHP payment. For CY 2009, payment will be denied for days when fewer than three units of therapeutic services are provided. The three units of service are a minimum threshold that permits unforeseen circumstances, such as medical appointments, while allowing payment, but still maintains the integrity of a comprehensive program.

**3.7.4.4** The following are billing instructions for submission of partial hospitalization claims/ services:

**3.7.4.4.1** Hospitals are required to use HCPCS codes and report line item dates for their partial hospitalization services. This means that each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of services are reported in Form Locator (FL) 45 "Services Date" (MMDDYY) of the CMS 1450 UB-04.

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 13, Section 2

Billing And Coding Of Services Under Ambulatory Payment Classifications (APC) Groups

**3.7.4.4.2** The following is a complete listing of the revenue codes and HCPCS codes that may be billed as partial hospitalization services or other mental health services outside partial hospitalization:

**FIGURE 13.2-5 REVENUE AND HCPCS LEVEL I AND II CODES USED IN BILLING FOR PARTIAL HOSPITALIZATION SERVICES AND OTHER MENTAL HEALTH SERVICES OUTSIDE PARTIAL HOSPITALIZATION FOR CY 2009<sup>1</sup>**

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I <sup>5</sup> AND II CODES
0250	Pharmacy	HCPCS code not required
043X	Occupational Therapy	G0129 <sup>2</sup>
0900	Behavioral Health Treatment/Services	90801 or 90802
0904	Activity Therapy (Partial Hospitalization)	G0176 <sup>3</sup>
0911	Psychiatric General Services	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90874, 90877 - 90879, and 90899
0914	Individual Psychotherapy	90816 - 90819, 90821 - 90824, 90826 - 90829, 90845, or 90865
0915	Group Therapy	G0410 or G0411
0916	Family Psychotherapy	90846 or 90847
0918	Psychiatric Testing	96101 - 96103, 96116, or 96118 - 96120
0942	Education Training	G0177 <sup>4</sup>

<sup>1</sup> The contractor will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The contractor will not edit for matching the revenue code to HCPCS.

<sup>2</sup> The definition of code G0129 is as follows:

**Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).**

<sup>3</sup> The definition of code G0176 is as follows:

**Activity therapy, such as music, dance, art or play therapies not for recreation, related to care and treatment of patient's disabling mental problems, per session (45 minutes or more).**

<sup>4</sup> The definition of code G0177 is as follows:

**Training and educational services related to the care and treatment of patient's disabling mental problems, per session (45 minutes or more).**

<sup>5</sup> HCPCS Level I/CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**Note:** Codes G0129 and G0176, are used only for PHPs. Code G0177 may be used in both PHPs and outpatient mental health setting. Revenue code 250 does not require HCPCS.

**3.7.4.4.3** To bill for partial hospitalization services under the hospital OPPS, hospitals are to use the above HCPCS and revenue codes and are to report partial hospitalization services under bill type 013X, along with condition code 41 on the CMS 1450 UB-04 claim form.

**3.7.4.4.4** The claim must include a mental health diagnosis and an authorization on file for each day of service. Since there is no HCPCS code that specifies a partial hospitalization related service, partial hospitalizations are identified by means of a particular bill type and condition code (i.e., 13X TOB with Condition Code 41) along with HCPCS codes specifying the individual services that constitute PHPs. In order to be assigned payment under Level II Partial Hospitalization Payment APC (0176) there must be four or more codes from PHP List B of which at least one code must come from PHP List A. In order to be assigned payment under Level I Partial Hospitalization

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 13, Section 2

Billing And Coding Of Services Under Ambulatory Payment Classifications (APC) Groups

Payment APC (0175) there must be a least three codes from PHP List B of which at least one code must come from PHP List A. List A is a subset of List B and contains only psychotherapy codes, while List B includes all PHP codes. (Refer to PHP Lists A and B in Figure 13.2-6). All other PHP services rendered on the same day will be packaged into the PHP APCs (0175 and 0176). All PHP lines will be denied if there are less than three codes/service appearing on the claim.

**FIGURE 13.2-6 PHP FOR CY 2008**

PHP LIST A	PHP LIST B	
90818	90801	90846
90819	90802	90847
90821	90816	90865
90822	90817	96101
90826	90818	96102
90827	90819	96103
90828	90821	96116
90829	90822	96118
90845	90823	96119
90846	90824	96120
90847	90826	G0129
90865	90827	G0176
G0410	90828	G0177
G0411	90829	G0410
	90845	G0411

**3.7.4.4.5** In order to assign the partial hospitalization APC to one of the line items (i.e., one of listed services/codes in Figure 13.2-5) the payment APC for one of the line items that represent one of the services that comprise partial hospitalization is assigned the partial hospitalization APC. All other partial hospital services on the same day are packaged; (i.e., the SI is changed from Q to N.) Partial hospitalization services with SI E (items or services that are not covered by TRICARE) or B (more appropriate code required for TRICARE OPPS) are not packaged and are ignored in the PHP processing.

**3.7.4.4.6** Each day of service will be assigned to a partial hospitalization APC, and the partial hospitalization per diem will be paid. Only one PHP APC will be paid per day.

**3.7.4.4.7** Non-mental health services submitted on the same day will be processed and paid separately.

**3.7.4.4.8** Hospitals must report the number of times the service or procedure was rendered, as defined by the HCPCS code.

**3.7.4.4.9** Dates of service per revenue code line for partial hospitalization claims that span two or more dates. Each service (revenue code) provided must be repeated as a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in "Service Date." Following are examples of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 13, Section 2

Billing And Coding Of Services Under Ambulatory Payment Classifications (APC) Groups

**FIGURE 13.2-7 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - HIPAA 837 FORMAT**

RECORD TYPE	REVENUE CODE	HCPCS	DATES OF SERVICE	UNITS	TOTAL CHARGE
61	0915	90849	19980505	1	\$80
61	0915	90849	19980529	2	\$160

**FIGURE 13.2-8 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - CMS 1450 FORMAT**

REVENUE CODE	HCPCS	DATES OF SERVICE	UNITS	TOTAL CHARGES
0915	90849	050598	1	\$80
0915	90849	052998	2	\$160

**Note:** Each line item on the CMS 1450 UB-04 claim form must be submitted with a specific date of service to avoid claim denial. The header dates of service on the CMS 1450 UB-04 may span, as long as all lines include specific dates of service within the span on the header.

**3.7.5** Reimbursement for a day of outpatient mental health services in a non-PHP program (i.e., those mental health services that are not accompanied with a condition code 41) will be capped at the partial hospital per diem rate. The payments for all of the designated Mental Health (MH) services will be totaled with the same date of service. If the sum of the payments for the individual MH services standard APC rules, for which there is an authorization on file, exceeds the Level II Partial Hospitalization APC (0176), a special MH services composite payment APC (APC 0034) will be assigned to one of the line items that represent MH services. All other MH services will be packaged. The MH services composite payment APC amount is the same as the Level II Partial Hospitalization APC per diem rate. MH services with SI **E** or **B** are not included in payments that are totaled and are not assigned the daily mental health composited APC amount.

**3.7.6** Freestanding psychiatric partial hospitalization services will continue to be reimbursed under all-inclusive per diem rates established under [Chapter 7, Section 2](#).

### **3.8 Payment Policy for Observation Services**

#### **3.8.1 Observations For Non-Maternity Conditions**

**3.8.1.1** Effective for dates of service on or after January 1, 2008, no separate payment will be made for observation services reported with HCPCS code G0378. Instead these hourly observation services will be assigned the SI of **N**, signifying that payment is always packaged.

**3.8.1.2** However, in certain circumstances when observation care is provided as an integral part of a patient's extended encounter of care, payment may be made for the entire care encounter through one of two composite APC when certain criteria are met.

**3.8.1.2.1** APC 8002 (Level I Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct admission to observation in conjunction with observation services of substantial duration (eight or more hours).

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MET	Microcurrent Electrical Therapy

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
<b>OAE</b>	<b>Otoacoustic Emissions</b>
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO <sub>2</sub>	Partial Pressure of Carbon Dioxide
PAO <sub>2</sub>	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

PCS	Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCC	Recurring Credit/Debit Charge <b>Renal Cell Carcinoma</b>
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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TRIAP	TRICARE Assistance Program
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouses

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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URL	Universal Resource Locator
US	Ultrasound United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Appendix A

Acronyms And Abbreviations

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WC	Worker's Compensation
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

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